SURGERY

UNDER THE CHARGE OF
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Intrathoracic Surgery.—LAPEYRE (*Archiv. d. Chir.*, 1913, vii, 1909) reviews the status of present day intrathoracic surgery. The difficulties previously encountered in making an accurate diagnosis, which should precede operation, have been largely overcome by the *x*-ray, and the fear of dangerous pneumothorax by various methods of artificial respiration during the operation. It is important to regard total pneumothorax as a rapidly fatal condition. Artificial respiration is not absolutely necessary in all cases, for instance in operations on the anterior mediastinum, as in operations on the heart and for tuberculous lymph nodes. The operation field in a posterior mediastinotomy is so small and deep that it is best reached through the pleural cavity, so that artificial respiration is necessary in this operation, In operating on the pleural cavity, the presence or absence of adhesions is very important. If adhesions are present, artificial respiration is not necessary, but it is absolutely necessary if the pleura is normal. The Sauerbruch chamber and Brauer apparatus are costly and little employed. The method of Meltzer is much more simple and is sufficiently dependable. Lapeyre has tried to simplify this method by interrupting the current of air being sent into the lungs by the bellows used for artificial respiration in the physiological laboratory. This method was employed in animals in four large thoracotomies (circular suture of the esophagus, pericardiorrhaphy, resection of the pneumogastrics), without any disturbance being noted in the blood. He does not insist on this method but believes that with further development it can be of much value.

Post-traumatic Ossification in the Region of the Elbow-joint.—LEHMAN (*Deut. Zschr. f. Chir.*, 1914, cxxvi, 213) says that the elbow-joint, more than other joints, exhibits a predilection for post-traumatic ossification: To a certain extent this is due to its anatomical formation. These ossifications may be found after traumata of every kind, but are especially frequent after dislocations. The trauma is the determining factor. Etiologically, an individual predisposition must be assumed. The bone formation may take place from intramuscular connective tissue, as well as from the periosteum. There is practically no difference between the ossification of muscle origin and that of periosteal origin, since both develop together. The neighboring soft tissues participate in the structure of the callus. Appropriate treatment of the recent injury is the best prophylaxis of the ossification. It involves rest and protection of the injured soft tissues, as far as possible, and the promotion of absorption. Vigorous massage and active movements are to be strictly avoided. For persistent thick infiltration, fibrolysin treatment is to be recommended. The completed ossification is capable of undergoing absorption, so that its treatment should be mostly conservative. An operation is indicated only in long continued, severe disturbances of function, and when there are complications from pressure on nerves and vessels. It should not be done before the conclusion of the process of ossification.

The Indications in Operations for Aneurysm and for Injury of the Bloodvessels.—Coenen (*Zentralbl. f. Chir.*, 1913, xl, 1913) says that whether one must treat traumatic aneurysms by ligature of the afferent and efferent branches with extirpation of the sac or by the employment of the vessel suture, and further, whether an injured large bloodvessel should be ligated or the vessel suture employed, depends on development of the collateral circulation. This should be determined before or at the time of the operation. From his experience with aneurysms in the first and second Balkan wars he developed the following method of testing the collateral circulation: Without interruption of the current the aneurysmal sac and the artery at each end are exposed. The artery is ligated above and below, close to the sac. Then below (on the peripheral side) the ligature a clamp is applied and the artery divided between this clamp and the peripheral ligature. If the clamp is now removed and bright red blood escapes from the open peripheral stump a sufficient collateral circulation is present, and one may safely apply the ligature (positive collateral sign). But if no blood escapes from the open peripheral stump, then it may be assumed, provided that a thrombus has not developed, that no collateral circulation has formed (negative collateral sign), and the vessel suture with implantation into the saphenous vein is indicated. The color of the toes or fingers help in determining the condition of the collateral circulation as well as the color of the blood which escapes from a puncture in the affected region. One cannot always wait for the stationary stage of the aneurysm nor for the complete fibrous encapsulation of the sac and formation of the collateral circulation. This is the case in war hospitals or when the escaping blood is progressively infiltrating the muscles and producing nerve paralyses. In such cases it may be necessary to operate and expose the vessels with the limb made bloodless by the Esmarch tourniquet. After clamping the vessel above and below the Esmarch band may be removed and the above test of the colateral circulation made. He operated on three stationary and four progressive aneurysms. In two, saphenous implantations were made. Gangrene did not occur in any.

Gastroduodenostomy for Ulcer.—Brun (*Zentralbl. f. Chir.*, 1914, xli, 140) has been employing for a year gastroduodenostomy instead of gastrojejunostomy for florid pylorus and duodenal ulcer. He calls attention to the mobility of the duodenum and its availability in this